**Texas Department of Insurance**
***Division of Workers' Compensation***
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

# *MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION*

## *GENERAL INFORMATION*

**Requestor Name and Address**

VISTA MEDICAL CENTER HOSPITAL
4301 VISTA ROAD
PASADENA TEXAS 77504

**Carrier's Austin Representative Box**
19

**MFDR Date Received**
APRIL 10, 2006

**Respondent Name**
BANKERS STANDARD INS CO

**MFDR Tracking Number**
M4-06-5151-01

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary Dated April 25, 2006:** "The Carrier has not made a legal denial of reimbursement under the applicable rules and statutes." "Carrier may reimburse at a 'per diem' rate for the hospital services if the total audited charges for the entire admission are below $40,000, after the Carrier audits the bill pursuant to the applicable rules." "In this instance, the audited charges that remained in dispute after the last bill review by the insurance Carrier **$133,894.37**...The prior amounts paid by the Carrier were **$20,754.00**. Therefore, the Carrier is required to reimburse the remainder of the Workers' Compensation reimbursement amount of **$79,666.77,** plus any and all interest applicable."

**Requestor's Supplemental Position Summary Dated October 28, 2011:** "Please allow this letter to serve as a supplemental statement to Vista's originally submitted request for dispute resolution in consideration of the Texas Third Court of Appeals' Final Judgment…The medical records on file with MDR show this admission to be a complex spine surgery which is unusually extensive for at least three reasons…The medical and billing records on file with MDR also show that this admission was unusually costly for two reasons…"

**Amount in Dispute:** $79,666.78

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary Dated April 26, 2006:** "It is the carrier's position that the hospital admission was not 'unusually costly' or 'unusuall extensive' & thereof does not trigger th stop loss methodology as outlined in TDI-DWC rule 134.401 It is the carrier's position that bill was appropriately using the per-diem." [sic]

**Responses Submitted by:** Broadspire on behalf Bankers Standard Insurance, P.O. Box 701809, Dallas, TX 75370

**Respondent's Supplemental Position Summary Dated September 12, 2011:** "Respondent submits this Respondent's Post-Appeal Supplemental Response as a response to and incorporation of the Third Court of

Appeals Mandate in Cause No. 03-07-00682-CV…Based upon Respondent's initial and all supplemental responses, and in accordance with the Division's obligation to adjudicate the payment, in accordance with the Labor Code and Division rules, Requestor has failed to sustain its burden of proving entitlement to the stop-loss exception. The Division must conclude that payment should be awarded in accordance with the general *per diem* payment in accordance with 28 Texas Administrative Code §134.401 (repealed)…"

**Response Submitted by:** Flahive, Ogden & Latson, 505 West 12th Street, Austin, Texas 78701

## *SUMMARY OF FINDINGS*

| Disputed Dates | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| August 1, 2005 through August 5, 2005 | Inpatient Hospital Services | $79,666.78 | $481.52 |

## *FINDINGS AND DECISION*

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

1. 28 Texas Administrative Code §133.304, 17 *Texas Register* 1105, effective February 20, 1992, amended effective July 15, 2000 sets out the procedures for medical payments and denials
2. 28 Texas Administrative Code §133.305 and §133.307, 27 *Texas Register* 12282, applicable to requests filed on or after January 1, 2003, sets out the procedures for resolving medical fee disputes.
3. 28 Texas Administrative Code §134.401, 22 *Texas Register* 6264, effective August 1, 1997, sets out the fee guidelines for inpatient services rendered in an acute care hospital.
4. 28 Texas Administrative Code §134.1, 27 *Texas Register* 4047, effective May 16, 2002, sets out the guidelines for a fair and reasonable amount of reimbursement in the absence of a contract or an applicable Division fee guideline.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of Benefits
   - 45-Charges exceed your contracted/legislated fee arrangement.
   - 5-The procedure code/bill type is inconsistent with the place of service.
   - W1, 147-Workers compensation state fee schedule adjustment.
   - 18-Duplicate claim/service.
   - 476-$74,631.87 of the charges are duplicates of bill # 888-U-4986248-0.
   - 886-Reimbursement not recommended as service appears to be a duplicate of another service billed on the same date of service.
   - 975-640-Nurse review in-patient hospital/facility bill.
   - 112-003-The primary provider is a non-contracted provider with FOCUS.
   - 112-No additional reimbursement allowed after review of appeal/reconsideration.
   - 864-Invoice necessary for reimbursement.
   - 885-999-Review of this code has resulted in an adjusted reimbursement.
   - 900-Based on further review, no additional allowance is warranted.
   - 975-410-Copy of provider's invoice used to determine reimbursable amount.
   - W4-No additional reimbursement allowed after review of appeal/reconsideration.

**Issues**

1. Did the respondent provide sufficient explanation for denial of the disputed services?
2. Did the audited charges exceed $40,000.00?
3. Did the admission in dispute involve unusually extensive services?
4. Did the admission in dispute involve unusually costly services?
5. Does a contractual agreement issue exist?
6. Is the requestor entitled to additional reimbursement?

**Findings**

This dispute relates to inpatient surgical services provided in a hospital setting with reimbursement subject to the provisions of Division rule at 28 Texas Administrative Code §134.401, titled *Acute Care Inpatient Hospital Fee Guideline*, effective August 1, 1997, 22 Texas Register 6264. The Third Court of Appeals' November 13, 2008 opinion in *Texas Mutual Insurance Company v. Vista Community Medical Center, LLP*, 275 *South Western Reporter Third* 538, 550 (Texas Appeals – Austin 2008, petition denied) addressed a challenge to the interpretation of 28 Texas Administrative Code §134.401. The Court concluded that "to be eligible for reimbursement under the Stop-Loss Exception, a hospital must demonstrate that the total audited charges exceed $40,000 and that an admission involved unusually costly and unusually extensive services." Both the requestor and respondent in this case were notified via form letter that the mandate for the decision cited above was issued on January 19, 2011. Each was given the opportunity to supplement their original MDR submission, position or response as applicable. The Division received supplemental information as noted in the position summaries above. The supplemental information was shared among the parties as appropriate. The documentation filed by the requestor and respondent to date will be considered in determining whether the admission in dispute is eligible for reimbursement under the stop-loss method of payment. Consistent with the Third Court of Appeals' November 13, 2008 opinion, the division will address whether the total audited charges ***in this case*** exceed $40,000; whether the admission and disputed services ***in this case*** are unusually extensive; and whether the admission and disputed services ***in this case*** are unusually costly. 28 Texas Administrative Code §134.401(c)(2)(C) states, in pertinent part, that "Independent reimbursement is allowed on a case-by-case basis if the particular case exceeds the stop-loss threshold as described in paragraph (6) of this subsection…" 28 Texas Administrative Code §134.401(c)(6) puts forth the requirements to meet the three factors that will be discussed.

1. The requestor asserts in its position statement that "The Carrier has not made a legal denial of reimbursement under the applicable rules and statutes." "…Vista was not provided with a sufficient explanation or the proper denial reasons to justify the denial of reimbursement of the disputed charges upon reconsideration. Title 28, TEX. ADMIN. CODE §133.304(c), sets forth the specific requirements that a carrier must follow in reducing or denying payment for medical services." 28 Texas Administrative Code §133.304(c), 17 Texas Register 1105, effective February 20, 1992, applicable to dates of service in dispute, states, in pertinent part, that "At the time an insurance carrier makes payment or denies payment on a medical bill, the insurance carrier shall send, in the form and manner prescribed by the Commission, the explanation of benefits to the appropriate parties. The explanation of benefits shall include the correct payment exception codes required by the Commission's instructions, and shall provide sufficient explanation to allow the sender to understand the reason(s) for the insurance carrier's action(s). A generic statement that simply states a conclusion such as 'not sufficiently documented' or other similar phrases with no further description of the reason for the reduction or denial of payment does not satisfy the requirements of this section." Review of the submitted documentation finds that the explanation of benefits were issued using the Division-approved form TWCC 62 and noted payment exception codes: "45-Charges exceed your contracted/legislated fee arrangement"; "5-The procedure code/bill type is inconsistent with the place of service"; "W1, 147-Workers compensation state fee schedule adjustment"; "18-Duplicate claim/service"; "476-$74,631.87 of the charges are duplicates of bill # 888-U-4986248-0"; "886-Reimbursement not recommended as service appears to be a duplicate of another service billed on the same date of service"; "975-640-Nurse review in-patient hospital/facility bill"; "112-003-The primary provider is a non-contracted provider with FOCUS"; "112-No additional reimbursement allowed after review of appeal/reconsideration"; "864-Invoice necessary for reimbursement"; "885-999-Review of this code has resulted in an adjusted reimbursement"; "900-Based on further review, no additional allowance is warranted"; "975-410-Copy of provider's invoice used to determine reimbursable amount"; and "W4-No additional reimbursement allowed after review of appeal/reconsideration" for the services in dispute.

   These payment exception codes and descriptions support an explanation for the reduction of reimbursement based on former 28 Texas Administrative Code §134.401. These reasons support a reduction of the reimbursement amount from the requested stop-loss exception payment reimbursement methodology to the standard per diem methodology amount and provided sufficient explanation to allow the provider to understand the reason(s) for the insurance carrier's action(s). The Division therefore concludes that the insurance carrier has substantially met the requirements of 28 Texas Administrative Code §133.304(c).

2. 28 Texas Administrative Code §134.401(c)(6)(A)(i) states "…to be eligible for stop-loss payment the total audited charges for a hospital admission must exceed $40,000, the minimum stop-loss threshold." Furthermore, (A) (v) of that same section states "…Audited charges are those charges which remain after a bill review by the insurance carrier has been performed…" Review of the explanation of benefits issued by the carrier finds that the carrier did not deduct any charges in accordance with §134.401(c)(6)(A)(v); therefore

the audited charges equal $133,894.37. The Division concludes that the total audited charges exceed $40,000.

3. The requestor in its original position statement asserts that "Carrier may reimburse at a 'per diem' rate for the hospital services if the total audited charges for the entire admission are below $40,000, after the Carrier audits the bill pursuant to the applicable rules." "In this instance, the audited charges that remained in dispute after the last bill review by the insurance Carrier **$133,894.37**...The prior amounts paid by the Carrier were **$20,754.00**. Therefore, the Carrier is required to reimburse the remainder of the Workers' Compensation reimbursement amount of **$79,666.77**, plus any and all interest applicable." As noted above, the Third Court of Appeals' November 13, 2008 opinion in *Texas Mutual Insurance Company v. Vista Community Medical Center, LLP*, 275 *South Western Reporter Third* 538, 550 (Texas Appeals – Austin 2008, petition denied) rendered judgment to the contrary. In its supplemental position statement, the requestor considered the Courts' final judgment and opined on both rule requirements. In regards to whether the services were unusually extensive, the Third Court of Appeals' November 13, 2008 opinion concluded that in order to be eligible for reimbursement under the stop-loss exception, a hospital must demonstrate that an admission involved unusually extensive services. Rule §134.401(c)(2)(C) allows for payment under the stop-loss exception on a case-by-case basis only if the particular case exceeds the stop-loss threshold as described in paragraph (6). Paragraph (6)(A)(ii) states that "This stop-loss threshold is established to ensure compensation for unusually extensive services required during an admission." The requestor's supplemental position statement asserts that:

   > "The medical records on file with MDR show this admission to be a complex spine surgery which is unusually extensive for at least three reasons; first, this type of surgery is unusually extensive when compared to all surgeries performed on workers' compensation patients in that only 19% of such surgeries involved operations on the spine; second, this type of surgery requires additional, trained nursing staff and specialized equipment (such as the operating table) thereby making the hospital services unusually extensive; and third, the median length of stay ("LOS") for workers' compensation inpatient admissions is three days whereas the length of stay for this admission exceeds the median LOS. Finally, any evidence of comorbidities, which should be considered, is part of the medical records, which have been previously filed."

   The requestor's categorization of spinal surgeries presupposes that all spinal surgeries are unusually extensive for the specified reasons. The requestor did not submit documentation to support the reasons asserted, nor did the requestor point to any sources for the information presented. The reasons stated are therefore not demonstrated. Additionally, the requestor's position that all spinal surgeries are unusually extensive does not satisfy §134.401(c)(2)(C) which requires application of the stop-loss exception on a case-by-case basis. The Third Court of Appeals' November 13, 2008 opinion affirmed this, stating "The rule further states that independent reimbursement under the Stop-Loss Exception will be 'allowed on a case-by-case basis.' *Id.* §134.401(c)(2)(C). This language suggests that the Stop-Loss Exception was meant to apply on a case-by-case basis in relatively few cases." The requestor's position that all spine surgeries are unusually extensive fails to meet the requirements of §134.401(c)(2)(C) because the particulars of the services in dispute are not discussed, nor does the requestor demonstrate how the services in dispute were unusually extensive in relation to similar spinal surgery services or admissions. For the reasons stated, the Division finds that the requestor failed to demonstrate that the services in dispute were unusually extensive.

4. In regards to whether the services were unusually costly, the Third Court of Appeals' November 13, 2008 opinion concluded that in order to be eligible for reimbursement under the stop-loss exception, a hospital must demonstrate that an admission involved unusually costly services. 28 Texas Administrative Code §134.401(c)(6) states that "Stop-loss is an independent reimbursement methodology established to ensure fair and reasonable compensation to the hospital for unusually costly services rendered during treatment to an injured worker." The requestor's supplemental position statement asserts that:

   > "The medical and billing records on file with MDR also show that this admission was unusually costly for two reasons: first the median charge for all workers' compensation inpatient surgeries is $23,187; the median charge for workers' compensation surgeries of this type is $39,000; therefore, the audited billed charges for this surgery substantially exceed not only the median charges, but also the $40,000 stop-loss threshold; second, as mentioned in the preceding paragraph, in order for this surgery to be performed, specialized equipment and specially trained, extra nursing staff were required, thereby adding substantially to the cost of the surgery in comparison to other types of surgeries; and third, it was necessary to purchase expensive implants for use in the surgery."

   The requestor asserts that because the ***billed charges*** exceed the stop-loss threshold, the admission in this case is unusually costly. The Division notes that audited charges are addressed as a separate and distinct

factor described in 28 Texas Administrative Code §134.401(c)(6)(A)(i). Billed charges for services do not represent the cost of providing those services, and no such relation has been established in the instant case. The requestor fails to demonstrate that the ***costs*** associated with the services in dispute are unusual when compared to similar spinal surgery services or admissions. For that reason, the Division rejects the requestor's position that the admission is unusually costly based on the mere fact that the billed or audited charges "substantially" exceed $40,000. The requestor additionally asserts that certain resources that are used for the types of surgeries associated with the admission in dispute (i.e. specialized equipment and specially-trained, extra nursing staff) added substantially to the cost of the admission. The requestor does not list or quantify the costs associated with these resources in relation to the disputed services, nor does the requestor provide documentation to support a reasonable comparison between the resources required for both types of surgeries. Therefore, the requestor fails to demonstrate that the resources used in this particular admission are unusually costly when compared to resources used in other types of surgeries.

5. According to the explanation of benefits, the carrier paid the services in dispute in accordance with a contracted or legislated fee arrangement. The "Contacted % Discount Reduction" amount on the submitted explanation of benefits denotes a "0.00" discount. The Division finds that the documentation does not support that the services were discounted due to a contract; therefore, reimbursement for the services in dispute will be reviewed in accordance with applicable Division rules and guidelines.
6. For the reasons stated above the services in dispute are not eligible for the stop-loss method of reimbursement. Consequently, reimbursement shall be calculated pursuant to 28 Texas Administrative Code §134.401(c)(1) titled *Standard Per Diem Amount* and §134.401(c)(4) titled *Additional Reimbursements.* The Division notes that additional reimbursements under §134.401(c)(4) apply only to bills that do not reach the stop-loss threshold described in subsection (c)(6) of this section.

- Review of the submitted documentation finds that the services provided were surgical; therefore the standard per diem amount of $1,118.00 per day applies. Division rule at 28 Texas Administrative Code §134.401(c)(3)(ii) states, in pertinent part, that "The applicable Workers' Compensation Standard Per Diem Amount (SPDA) is multiplied by the length of stay (LOS) for admission…" The length of stay is four days. The intensive care unit (ICU) rate of $1560.00 multiplied by the length of stay of one day is $1,560.00 added to $3,354.00 the surgical per diem rate of $1,118 multiplied by the length of stay of three days results in an allowable amount of $4,914.00.
- 28 Texas Administrative Code §134.401(c)(4)(A), states "When medically necessary the following services indicated by revenue codes shall be reimbursed at cost to the hospital plus 10%: (i) Implantables (revenue codes 275, 276, and 278), and (ii) Orthotics and prosthetics (revenue code 274)."
- A review of the submitted medical bill indicates that the requestor billed revenue code 278 for Implants at $59,262.50. The respondent paid $15,840.00.
- The Division finds the total allowable for the implants billed under revenue code 278 is:

| Description of Implant per Itemized Statement | Quantity | Cost Invoice | Cost + 10% |
|---|---|---|---|
| Screw Synthes | 3 | $29.25/each | $96.52 |
| Cortical Cancellous | 1 | $350.00 | $385.00 |
| Corlok Lumbar | 3 | $4800.00/each | $15,840.00 |
| TOTAL DUE | 7 | | $16,321.52 |

- 28 Texas Administrative Code §134.401(c)(4)(C) states "Pharmaceuticals administered during the admission and greater than $250 charged per dose shall be reimbursed at cost to the hospital plus 10%. Dose is the amount of a drug or other substance to be administered at one time." A review of the submitted itemized statement finds that the requestor billed $302.85/unit for Thrombin 5,000 unit and $289.00/unit for Dilaudid PCA 100ML.The requestor did not submit documentation to support what the cost to the hospital was for these items billed under revenue code 250. For that reason, additional reimbursement for these items cannot be recommended.

The division concludes that the total allowable for this admission is $21,235.52. The respondent issued payment in the amount of $20,754.00. Based upon the documentation submitted, additional reimbursement of $481.52 can be recommended.

**Conclusion**

The submitted documentation does not support the reimbursement amount sought by the requestor. The requestor in this case demonstrated that the audited charges exceed $40,000, but failed to demonstrate that the disputed inpatient hospital admission involved unusually extensive services, and failed to demonstrate that the services in dispute were unusually costly. Consequently, 28 Texas Administrative Code §134.401(c)(1) titled *Standard Per Diem Amount,* and §134.401(c)(4) titled *Additional Reimbursements* are applied and results on additional reimbursement.

## *ORDER*

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $481.52 plus applicable accrued interest per 28 Texas Administrative Code §134.803, due within 30 days of receipt of this Order

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**Authorized Signature**

| | | |
|---|---|---|
| | | 8/8/2012 |
| Signature | Medical Fee Dispute Resolution Officer | Date |

## *YOUR RIGHT TO APPEAL*

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812**.